DOCUMENT RESUME

ED 393 032 CG 026 844

AUTHOR	Smith, Albert J., Jr.
TITLE	School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts. A Series of Solutions and Strategies, Number 10.
SPONS AGENCY	National Dropout Prevention Center, Clemson, SC.
PUB DATE	Sep 95
NOTE	13p.
PUB TYPE	Collected Works - Serials (022)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Case Studies; *Caseworker Approach; Caseworkers; Demonstration Programs; *Dropout Prevention; Dropout Programs; *Early Intervention; Education Service Centers; Elementary Education; Elementary School Students; Evaluation; High Risk Students; Potential Dropouts; *School Based Management; *School Organization; School Personnel; School Restructuring
IDENTIFIERS	C STARS

ABSTRACT

This publication introduces school personnel concerned with early intervention with potential school dropouts to a promising school-based interprofessional case management model that has been successfully field-tested in 25 very different elementary school communities of Idaho and Washington State over the past 7 years: C-STARS (Center for the Study and Teaching of At-Risk Students). Case management is a service modality that cuts across several different human service systems, including education, that share common client populations of at-risk children and their families. Children and families who need case management services typically have two things in common: they experience concurrent problems which require assistance from more than one helper and they have special difficulty in using available help effectively. C-STARS involves partnerships among schools, community-based agencies that serve families and children residing in the schools' attendance areas, and universities for preparation of both school and community-based agency professionals. The following topics are reviewed: (1) C-STARS definition of case management; (2) seven functional components of the C-STARS model; (3) three structural components of the model; (4) the special roles and attributes of the case manager; (5) two most common applications of the model; (6) overall summary of evaluation findings; (7) benefits of school-based case management; and (8) getting started. Contains 19 references. (JBJ)

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A Series of
Solutions and Strategies

NATIONAL DROPOUT PREVENTION CENTER

September 1995 Number 10

ED 393 032

School-Based Case Management: An Integrated Service Model for Early Intervention with Potential Dropouts

by
Albert J. Smith, Jr., Ph.D.

Introduction: Sandy and Her Family

Sandy is in third grade at Briarwood Elementary. She is nine years old and is reading at a first grade level as assessed recently by district standardized tests. Ms. Andrews, her teacher, groups her students by ability, and Sandy is in the lowest reading group. She is big for her age and is teased by some classmates about her obesity and her lack of reading skills. Sandy hates going to school and frequently feigns illness to avoid going. She is often disruptive in class and has been sent to the principal several times for fighting and disturbing her classmates. She often appears tired and has fallen asleep in class several times. She qualifies for the school free-lunch program but avoids school lunches in favor of the candy bars and junk food she brings to school. When the school's Title 1 reading teacher comes twice a week to pull Sandy from class for special reading attention, she frequently balks and is sometimes openly upset. Sandy is angry and frustrated, and is failing in school.

Sandy lives with her mother and two younger brothers who are two and three years of age. Her mother is a high school dropout, divorced, and herself only 25 years old. Mom is unemployed and on welfare. She has worked as a waitress and shown talent with embroidery, knitting, and mending clothing. She thinks she'd like to be a seamstress and possibly a tailor, but doesn't know how to achieve this goal. She is aware of her daughter's problems with school as well as her obesity and emotional problems, but doesn't know whom to go to for help. A neighbor suggested she go to the local state office for Family and Children's Services. She went, but wasn't able to sufficiently complete the form required to see a counselor, so she left. She has had similar experiences at other community-based agencies when she's gone looking for help with employment training, her bouts of depression, and child care while job seeking. Mom has several needs that no single agency, including Sandy's school, seems to be able to address. She doesn't know what to do or where to turn next.

The situation faced by Sandy and her mother features many of the characteristics of school children and their families with multiple health, education, and social service needs that no single agency is in a position to address alone. One intervention strategy that many schools are now beginning to use in these situations is a case management approach which emanates from the schools' concern for children who are failing in school due to a variety of interacting school, home, and community influences.

The purpose of this publication is to introduce school personnel concerned with early intervention with potential school dropouts to a promising school-based interprofessional case management model that has been successfully field-tested in 25 very different elementary school-communities of Idaho and Washington State over the past seven years.

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What is Case Management?

Case management is a service modality that cuts across several different human service systems, including education, that share common client populations of at-risk children and their families. These children and their families have a variety of immediate health, education, and social service needs that no single institution alone is capable of addressing effectively. In essence, case management is a series of actions and a process to assure that clients of human services receive the services, treatment, care, and opportunities to which they are entitled. (Weil, Karls, & Associates, 1985).

Case management is the only method used by human service agencies that has as its target children and families that experience a variety of multiple and concurrent problems, while at the same time experiencing difficulties in accessing and using services available from different professionals and service systems (Ballew & Mink, 1986).

Though the concept has been used for over a hundred years in the United States under a variety of different names (Weil, Karls, & Associates, 1985), the current application of the concept associated with the term "case management" has been in use for about 40 years (Rothman, 1992).

The term "case management" conjures up a wide variety of notions and reactions among educators and human service professionals alike, some of which border on cynicism and trepidation (Weil, Karls, & Associates, 1985). After all, the word "case" implies for many an inherent deficiency or an illness of some sort as in "a mental case" or "a case of the flu."

While the term and its many synonyms vary in use among service institutions, research studies on case management use in a variety of service settings show there is a common set of functions which operationally define case management (Rothman, 1992; Weil, Karls, & Associates, 1985). These are identifying and attracting clients, intake and assessment, developing a coordinated service plan, advocating on behalf of the client(s) while brokering and linking different services together, implementing and monitoring service delivery, and continually evaluating and adjusting the service delivery plan while determining outcomes clients are or are not achieving.

The Need for School-Based Interprofessional Case Management

Children and families who need case management services typically have two things in common. First, they experience several concurrent problems which require assistance from more than one helper; and second, they have special difficulty in using available help effectively (Ballew & Mink, 1986).

In school settings, these often are children who are distracted from learning due to a variety of risk factors associated with dropping out of school. Examples of risk factors are low birth weight; single parent family situations; and emotional, physical, and/or sexually abusive environments.

Schorr (1988) makes the point that risk factors leading to later damage occur more frequently among children in families that are poor and that the plight of children bearing these risks is not just individual and personal; it requires a societal response. Conservative estimates now indicate that about one of four children in America's schools is living in poverty (Hodgkinson, 1989).

The number of child neglect and/or abuse reports nationwide has risen dramatically over the past 20 years. People in poverty today are often from second or third generation poverty stricken families. Not only do at-risk children have multiple health, education, and social service needs, but their parents have a variety of service needs as well. In order to assure readiness to learn for the child while at the same time assuring a readiness to parent among adult family members, home environmental needs have to be addressed. Case management in this scenario then requires a holistic approach addressing the child's total environment, not just the hours spent each day in school.

Children, by virtue of their dependence on adults for food, clothing, shelter, education, support, and love, are a vulnerable population. Children must rely on these adults, usually family members, to fulfill their basic physical, emotional, and psychological needs. When these needs aren't met, case management is often needed for children whose families have not been able to adequately provide for their growth and development or whose parents or guardians have been abusive or neglectful.

Overview of the C-STARS Model

The Center for the Study and Teaching of At-Risk Students (C-STARS) has been developing and evaluating a school-based model for case management for over seven years. The C-STARS model for school-based interprofessional case management involves partnerships between schools, community-based agencies that serve families and children residing in the schools' attendance areas, and universities responsible for preparation of both school and community-based agency professionals.

The university role is to facilitate linkages between schools and their neighboring community-based agencies as they integrate

delivery of their respective health, education, and social services to common client populations of at-risk children and their families. Universities are uniquely suited for this role as they typically provide the professional preparation for most of the professionals across service systems attempting to link together and collaborate.

In this context, interdisciplinary faculty teams can often play a "third party" mediative role in facilitating linkages between school personnel and personnel from a variety of human service agencies.

The C-STARS Definition of Case Management

Although there is a consensus in the research regarding the basic functions of case management, the degree to which individual programs perform each function varies widely (Rothman, 1992). These functions were referenced and adapted by C-STARS in developing an operational definition of school-based and/or linked case management and a corresponding set of application guidelines.

C-STARS defines school-based interprofessional case management as: *A series of logical and appropriate interactions within a comprehensive service network of schools and social service and health agencies responsible for the well-being of common client populations of children and families. These interactions maximize opportunities for children at risk of school failure and their families to receive a variety of needed services in a supportive, efficient, and coordinated manner while empowering parents and guardians.*

The Seven Functional Components of This Model

Seven key functions characterize interprofessional case management at each C-STARS site. These are:

1. ***Assessment.*** Interprofessional case management team members collaboratively identify causes of targeted students' difficulties. These barriers to personal and academic success include circumstances unique to the student as well as those associated with school, family, or environment.

2. ***Development of a Service Plan.*** The interprofessional team develops a plan of coordinated multiple services tailored to each student. This plan generally includes a mix of short-term and long-range services that are delivered both in and out of school by the case management team and the community service network.

3. ***Brokering.*** The case management team links targeted students and families to needed services that cannot be provided in the school, drawing upon the community service network in arranging for services beyond the team members' scope. Brokering involves much more than simply making a referral. Pre-referral counseling and family outreach activities help students and their families to accept services. In times of crisis, a team member accompanies the student and/or family members to the referral agency.

4. **Service Implementation and Coordination.** The implementation function of case management team members is twofold: first, they deliver selected services on-site; second, they ensure that all services to a student are working together for that student's benefit and that appropriate communication is taking place among the various service providers. One member of the team is generally responsible for service coordination.

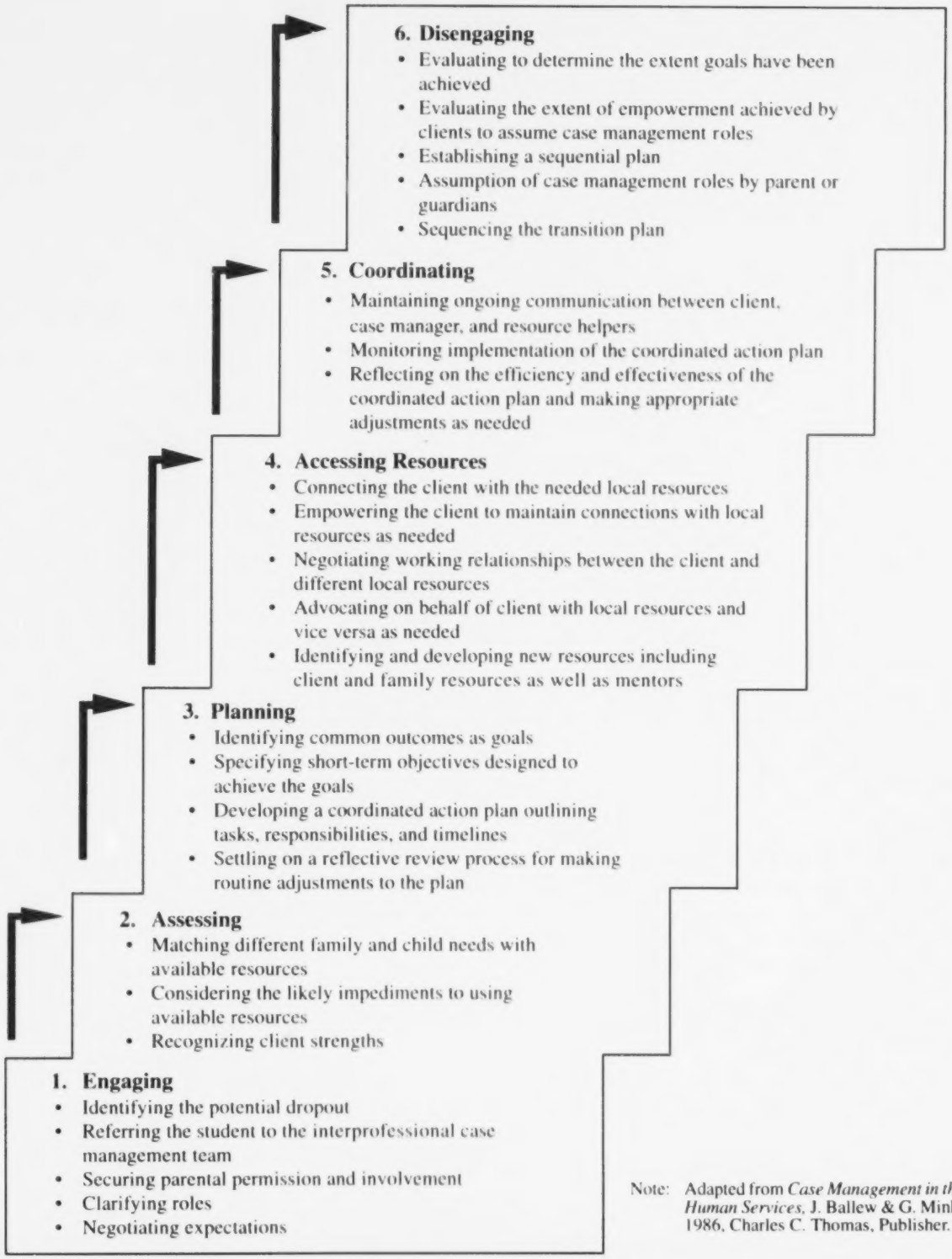
5. ***Advocacy.*** Team members advocate for students and families by assisting and mediating student-family communications within or outside service agencies or school. Advocacy also includes helping the student and/or family negotiate the many different bureaucracies involved. Appropriate team members help to mediate and resolve conflicts and facilitate communication between students and family members, students and service providers, et al.

6. ***Monitoring and Evaluation.*** The interprofessional case management team tracks services delivered to the student and family and monitors the student's condition and emerging needs. As a result, adjustments in the service plan can be made and program milestones documented as circumstances dictate.

7. ***Mentoring.*** One member of the interprofessional case management team is designated as the primary professional caring for each student within the partnership of service agencies. No matter the number of specialists involved, this person follows through for the student and/or family and is the person with whom the student and his/her family can comfortably communicate and to whom they can turn.

Figure 1 integrates the seven functional components of the C-STARS model into a six-stage framework described by Ballew & Mink (1986).

Figure 1. The Six Stages of School-based Interprofessional Case Management


6. Disengaging
• Evaluating to determine the extent goals have been achieved
• Evaluating the extent of empowerment achieved by clients to assume case management roles
• Establishing a sequential plan
• Assumption of case management roles by parent or guardians
• Sequencing the transition plan
5. Coordinating
• Maintaining ongoing communication between client, case manager, and resource helpers
• Monitoring implementation of the coordinated action plan
• Reflecting on the efficiency and effectiveness of the coordinated action plan and making appropriate adjustments as needed
4. Accessing Resources
• Connecting the client with the needed local resources
• Empowering the client to maintain connections with local resources as needed
• Negotiating working relationships between the client and different local resources
• Advocating on behalf of client with local resources and vice versa as needed
• Identifying and developing new resources including client and family resources as well as mentors
3. Planning
• Identifying common outcomes as goals
• Specifying short-term objectives designed to achieve the goals
• Developing a coordinated action plan outlining tasks, responsibilities, and timelines
• Settling on a reflective review process for making routine adjustments to the plan
2. Assessing
• Matching different family and child needs with available resources
• Considering the likely impediments to using available resources
• Recognizing client strengths
1. Engaging
• Identifying the potential dropout
• Referring the student to the interprofessional case management team
• Securing parental permission and involvement
• Clarifying roles
• Negotiating expectations

Note: Adapted from *Case Management in the Human Services*, J. Ballew & G. Mink, 1986, Charles C. Thomas, Publisher.

The Three Structural Components of This Model

There are three structural components of this model at each school-community site. These are (1) the case manager, (2) the interprofessional case management team, and (3) the community service network (Smith, Oaks, & Rosenberg, 1991).

The ***case manager*** identifies students at risk of school failure, refers at-risk students to the interprofessional case management team, facilitates regular meetings of this team, monitors the multiple service plan developed for each student, advocates with service agencies on behalf of the student and his/her family, and is often the single adult who maintains a sustained contact with the student and respective family throughout the delivery of the multiple services prescribed for the student. The case manager also ensures that information is collected for referral, assessment, and evaluation purposes, and coordinates the implementation of planned services.

The school-based ***interprofessional case management team*** includes, at minimum, the case manager, a social worker, and a health service professional. These can be school employees or nonschool employees associated with community-based agencies to work in schools or a mix of both. This team of service providers meets regularly with the case manager to collaboratively exercise the seven functions of this case management model. The members of the team are sometimes employees of local health, education and/or social service agencies who, through interagency agreements with school districts, provide in-kind staff time as school team members.

The ***comprehensive service network*** typically includes a range of local service providers who agree to coordinate with case managers and school-based interprofessional case management teams in delivering specific services as needed by students and their families beyond the professional expertise of the team members. These network a wide variety of individuals and institutions (e.g., Juvenile Justice, Planned Parenthood, the Council of Churches, County Public Health, and medical clinics).

Because each school-community will vary in consideration of resources available, local politics, and population characteristics, each school case management team follows a generic adaptation process in planning its unique version of this generic model. Included in this process is the (a) formation of a school-community steering committee (to ensure local ownership of the prevention/intervention program in each school-community); (b) selection and training of case managers (to serve as a consistent project contact with the targeted students and families, manage the implementation of comprehensive services plans, and ensure the appropriate delivery of the seven functions of case management); and (c) identification and orientation of interprofessional case management team members (education, health, and social service personnel who collectively focus on assessment, development of multiple service plans, monitoring, and service plan adjustments).

This adaptation process also helps ensure that other critical attributes of the case management team are met. These include identifying and orienting ancillary team members with expertise representing potential service needs of consumers, establishing service priorities for the at-risk students and/or families being served, and ensuring that confidentiality and other ethical standards are maintained.

Evaluation

The C-STARS approach to case management places a great emphasis on evaluation. This is especially important as policymakers and the general public demand accountability and evidence of cost-effectiveness and improvement in the risk factors affecting the students and/or families. Included in the C-STARS model are both formative and summative evaluation processes.

The formative evaluation tracks a team's process in delivering case management services. It is important that as the teams meet, they assess their own program activities and make adjustments if necessary. This helps ensure that the student's or family's comprehensive service plan is producing the desired results. To facilitate this process, C-STARS developed an action planning form for teams to use in the structuring of their coordinated service plans. This plan is periodically "revisited" to ensure that team activities are on track and, when necessary, modifications to the plan are made. This process is initially facilitated by the case manager designated for the specific child referral to the team.

The summative evaluation measures impact of case management services on the referred children and their families. This includes a systematic process designed to generate and/or retrieve data which at a minimum address (a) school performance, (b) school attendance, (c) dysfunctional behavior demonstrated at school, and (d) family involvement with school-student activities. C-STARS evaluators provide data forms, train site personnel, assist in data retrieval and analysis, and generate routine progress reports.

More recently, C-STARS partner school sites have been using the Computer-Assisted Risk Accountability System (CARAS) to enhance their evaluation and monitoring activities. This software program is used to monitor and document all aspects of the

case management process, from referral to case closure on each individual child and family. It enhances the development of individual service plans, up-to-date reports (on both individuals and an entire caseload), and generation and analysis of data for evaluation purposes (Armijo, Stowitschek, Smith, McKee, Solheim, & Phillips, 1994).

The Special Roles and Attributes of the Case Manager

In a nutshell, the job of the case manager is to work with at-risk children and their families to identify the type(s) of help needed, to empower families to identify and overcome barriers to using that help effectively, to directly intervene as necessary in order to overcome these barriers, to connect families and their children with potential help, and to facilitate and monitor the delivery of needed services in close communication with parents, teachers, and other case management team members.

The ultimate skill that case managers have to master and value is empowering children, parents, and family members to assume case manager roles themselves without an ongoing dependence on the case manager—put another way, "to let go" when the time is ripe. Ballew and Mink (1986) refer to this stage of the case management process as disengaging.

Figure 2 provides a generic job description for a school-based interprofessional case manager. Many C-STARS school-community partner sites are now using this as a starting point in developing job descriptions for school-based case managers.

The Two Most Common Applications of This Model by Participating School-Communities

Twenty-five elementary schools from five very different Washington State school districts recently participated with a four-year case management demonstration project funded by the U.S. Department of Education Dropout Prevention Demonstration and Assistance Program. C-STARS staff initially introduced these schools and their partner community-based agencies to the C-STARS case management model and then facilitated a planning process in which each site team adapted the definition, the three structural components, and the seven interrelated functions outlined in the model.

While each emerging plan was site specific and uniquely suited to its local characteristics, the approaches tended to cluster in two types of application: Redefinition of Job Descriptions: Existing School Personnel as Case Managers and Redefinition of School Procedures: Nonschool Personnel as Case Managers.

Strategy One: Redefinition of Job Descriptions—Existing School Personnel as Case Managers

Brief Snapshot of the Strategy

Some school districts have adapted the C-STARS model of school-based interprofessional case management by modifying the job descriptions of existing school personnel to include duties associated with case management. In most cases, existing school counselors, psychologists, and social workers who are assigned to a particular building have been selected to act as case managers. They work with an interprofessional building-based team to engage parents and service professionals, assess strengths and needs of the student and family, and develop a service plan. Team members typically include the parent of the child under consideration, the school counselor, a special education teacher, the school nurse, a lead teacher, and the principal.

Service providers who work with the family are sometimes invited to participate on the team when their clients are discussed. The counselor/case manager often takes a leadership role on the team and is responsible for monitoring the progress of the service plan. Team members, including the parents, may divide responsibilities for carrying out service plan activities. Counselors/case managers undertake the task of brokering outside services for the family since teachers and other school staff are less available for follow-up phone calls.

Results

The counselors who have participated in interprofessional case management have modified their interventions and strategies for their work with the students with the greatest need for services. They report that their involvement with families has increased, as has their contact with outside service providers. The average rate of absences, low and failing grades, and behavior referrals have all improved for students who had a high level of these school-related problems. Counselors who serve as case managers also noticed a great change in those parents who previously had little school involvement, to the extent of not returning notes or phone calls and avoiding entering the school building. According to counselors, many of these parents now visit with them at school and are active school partners. Some now volunteer regularly at school.

Advantages and Disadvantages

The school counselor/psychologist who also serves as a case manager has the advantage of operating in the day-to-day environment of the students served. Collaboration with teachers and other school staff is also facilitated by close contact and consultation.

Figure 2. Generic Job Description: School-Based Interprofessional Case Manager

Case managers identify students at risk of school failure associated with several personal, family, and/or school factors; assess multiple health, education, and social service needs of these students; develop an integrated school-community service delivery plan; and advocate on behalf of at-risk students.

Key Roles and Functions

1. Assist in the facilitation of regularly held meetings of the building case management team in order to plan, monitor, and adjust coordinated interprofessional services to at-risk students and their families.
2. Link students and their families with needed health and social services that cannot be provided by the case management team or other school personnel.
3. Ensure through monitoring and evaluation that all services being delivered to an individual student are working together for that student's benefit and that appropriate communication is taking place between service providers, students, and family members.
4. Advocate on behalf of students in order to secure needed services and entitlements.
5. Ensure that each student referred to the case management team has one team member identified to serve as the primary caring adult who will follow through with the student over a sustained period of time.
6. Anticipate potential student crisis situations that are likely to occur in the home, the school, and/or the community, and develop crisis intervention strategies with the case management team members and community service professionals.
7. Develop and maintain cooperative working relationships within the school between case management team members, teachers, counselors, administrators, et al., and outside the school with the family members as well as appropriate health and social service providers.
8. Determine the composition of each at-risk student's respective case management team in consideration of his/her holistic needs and available and/or appropriate resources (e.g., family members and social service case workers).

Qualifications and Experience

1. A Bachelor's degree in education, social work, health services or related field; Master's degree is preferred.
2. Must be able to clearly communicate orally and in writing, especially over the telephone.
3. Must have access to private automobile and possess a valid driver's license.
4. Must have experience in social service and/or educational program networking.
5. Must be sensitive to youth and ethnic cultural differences existing among at-risk populations, i.e., ability to establish a working rapport with different children and their families.
6. Must have some formal education that is multidisciplinary (e.g., education, sociology, psychology, and health sciences).
7. Must have a high energy level and tolerance to work with frustration associated with many bureaucratic practices and ambiguities.
8. Must be innovative and comfortable with trying new ways of working interprofessionally.
9. Must have an awareness of and appreciation for the barriers to interagency-school collaboration, such as the issues of turf and trust, and an acceptance of related implications associated with this particular job.
10. Must be a team player, able to lead as necessary, but also able to accept direction from a variety of professionals as appropriate to the interests of the children.
11. Must be flexible and able to adjust to programming shifts that occur in consideration of evaluation feedback.

They are readily accessible to parents and may find it easier to build a trusting relationship with parents than someone based at a district office.

The counselor/case manager's connection to resources in the community improves as a result of the brokering and advocacy that interprofessional case management requires. These connections and additional knowledge of community services benefits all of the students the counselor serves, not just those selected for case management.

The cost to the district of modifying the job descriptions of existing personnel to include responsibilities related to interprofessional case management is less than the cost of hiring additional staff to carry out those responsibilities. One disadvantage of this strategy is that counselors must divide their time between traditional counseling tasks and the duties of case management. High school counselors in particular find it difficult to carry out their testing and college and career guidance activities and still give adequate time to case management for the most seriously at-risk students. For this reason, a counselor/case manager is usually unable to serve as many students as a staff member hired specifically to do case management.

Strategy Two: Redefinition of School Procedures—Hiring Nonschool Personnel as Case Managers

Brief Snapshot of the Strategy

Some school districts have hired additional personnel to act as case managers. They usually serve more than one school and work from the central district office. The case manager serves as a contact person and liaison between school staff and community service providers. She or he may spend a great deal of time brokering services and advocating for students and families. This central office case manager serves on the interprofessional case management teams for each of the buildings she or he serves. These teams typically include the school counselor, nurse, principal, teachers, and representatives of special programs whose aims are to improve academic performance, student behavior, and/or school attendance. Representatives of agencies who serve many students and families from the school may also participate on these teams.

Results

Case managers who were hired to work from the central district office report that they have gained a great deal of knowledge about educational, social, and health services for students and families in their community. They have established close working relationships with staff at the agencies they call on frequently. They find that these relationships tend to "grease the wheels" and provide faster and more efficient access to needed services. School staff recognize this and readily make use of the case manager's services. For students who had a high level of absences, low grades, and behavior referrals at intake, the average rate of each of these school performance indicators improved by the end of the school year.

Advantages and Disadvantages

This variation has the advantage of focusing on the case manager's efforts on the responsibilities of case management. The district office case manager often has greater opportunities for establishing relationships with representatives of community agencies and programs, and develops a comprehensive knowledge of services available in the community.

This model also has some potential disadvantages. First, the services of a district-wide case manager may be spread very thinly as the case load increases. The case manager may be required to participate on as many as five interprofessional teams and serve as many as 40 students and families. Second, the central case manager often has less personal contact with students and families than the case manager located within the school building, and so may find it more difficult to individualize services, maintain student and family contact, and monitor services.

Other Variations of Case Management

Paraprofessionals and other existing school staff act as case managers in some school districts, often supplementing the services provided by school counselors and psychologists. Counseling assistants, family-community specialists, home visitors, behavior interventionists, and school administrators have all successfully provided interprofessional case management services. In addition, some community-based agencies have agreed to place case managers from their staffs in schools as regular members of school-based case management teams.

Overall Summary of Evaluation Findings: Impact of Case Management on At-Risk Children and Families

While the evaluation of C-STARS integrated service delivery activities includes tracking several case management-related outcomes, of particular importance are academic outcomes. Because past research shows that attendance, grades, and conduct are the most consistently referenced indicators of academic-

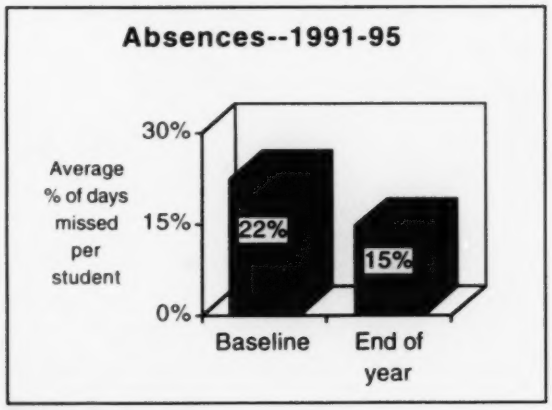
related performance (Stowitschek & Smith, 1990), C-STARS collects this data on all students receiving case management services. Students who may drop out of school at a later date typically show declines in attendance, grades, or conduct over the course of the school year. In addition, C-STARS tracked information by the case managers on needed areas of service for the families. Following is a summary of progress in each of these areas over a four-year period (1991-1995).

School Attendance

The percentage of school days missed is one of the primary measures C-STARS uses in determining the effectiveness of case management. Students are considered at risk if they miss 10% or more of their classes in a given quarter or semester. Baseline information is collected prior to the beginning of case management services and again at the end of the academic year, giving evaluators pre-post data to analyze.

During the four years of project activities (1991-1995), consistent improvement was seen as the percentage of days missed decreased for students meeting the C-STARS criteria and receiving case management services (Figure 3). The average percentage of absences per student was reduced by more than one-third, from 22% to 15%. An average of 54 students per year met the C-STARS criteria for high absentee rates at intake. By the end of each year, an average of 32 students per year were no longer at risk based on the C-STARS criteria for attendance referrals.

Figure 3. Average Absence Rates of At-Risk Students

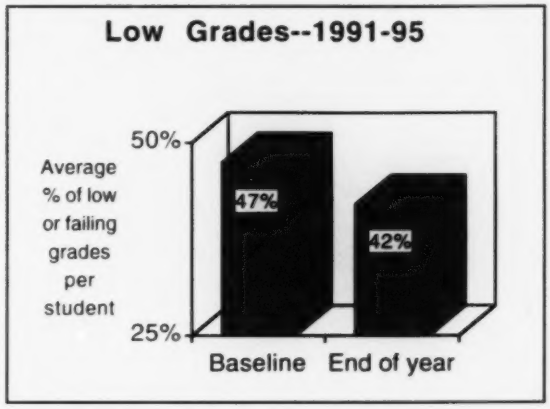


School Performance

The percentage of low or failing grades is another measure used by C-STARS to determine the academic impact case management has on at-risk students. Students are considered at risk if they receive low or failing grades in 10% or more of their academic subjects in a given quarter or semester. As is done with attendance, baseline information is collected prior to the beginning of case management services and again at the end of the academic year, giving evaluators pre-post date to analyze.

During each of the four years of project activities (1991-1995), consistent improvement was seen as the percentage of low or failing grades decreased for students meeting the C-STARS criteria and receiving case management services (see Figure 4). The average percentage of low or failing grades per students was reduced by an average of 5%, from 47% to 42%. At intake, an average of 93 targeted students per year met the C-STARS criteria for low or failing grades. By the end of each year, an average of 19 students per year were no longer at risk based on the C-STARS criteria for school performance referrals.

Figure 4. Average Rates of Low Grades for At-Risk Students



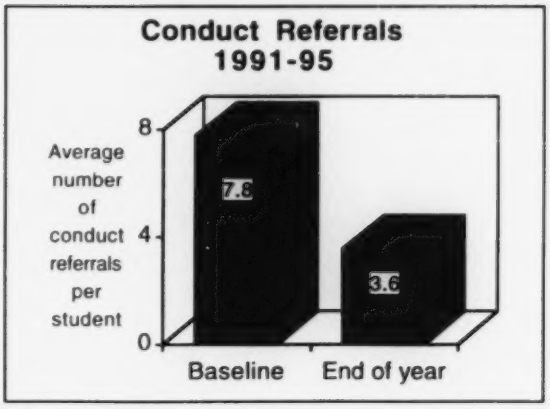
School Behavior

A third academically-related measure tracked by C-STARS is the number of conduct referrals received by at-risk students. Students are considered at risk if they are receiving three or more conduct referrals in a given quarter or semester. (The criterion was one or more conduct referrals for the first two years of the project.) As is done with attendance and grades, baseline information is collected prior to the beginning of case management services and again at the end of the academic year, giving evaluators pre-post data to analyze.

During the four years of project activities (1991-1995), consistent improvement was seen as the number of conduct referrals decreased for students meeting the C-STARS criteria and receiving case management services (see Figure 5). The average

number of conduct referrals per student was reduced by more than half, from almost eight referrals at baseline to less than four at the end of the year. An average of 60 students per year met the C-STARS criteria for conduct referrals at intake. By the end of each year, an average of 27 students per year were no longer at risk based on the C-STARS criteria for conduct referrals.

Figure 5. Average Number of Conduct Referrals for At-Risk Students



Family Access to Needed Services

During the last two years of the project, C-STARS began tracking areas of need for at-risk students and their families identified by case managers. During four years of project activities, case managers identified mental health, school connectedness (parent involvement with the school), and family relationships as the areas of greatest need. Each of these areas showed an improvement. Other areas of progress referenced by the case managers included family environment (e.g., adequate housing and utilities), food, and clothing.

Case managers also identified areas where they had some difficulty in obtaining progress. These included the areas of family income, physical health, and substance abuse.

The Benefits of School-Based Case Management

Over the years, participating case managers and members of case management teams have been interviewed on several occasions and asked to identify what they were experiencing as benefits associated with this particular intervention strategy. The benefits of school-based case management most frequently reported were that it:

- Encourages a sense of "community" in which the school is an integral community player in partnership with a variety of community service providers. School-based case management sends a message to the community that we care enough about your kids to reach out and link with a variety of human service providers and with families of children we're concerned about. For example, one district reports that the improved family access to services provided by this model has earned the district a county-wide reputation for provision of holistic family services that cannot be matched by other area districts. In another district, a family service agency was begun as a direct result of case managers' interventions and articulation of family service needs. This agency then served as a service agency referral resource for the district, its families, and other community residents.

- Provides educators, social workers, health service practitioners and parents with a "support group" of sorts in which all members of a team can rely on and draw support from the group as needed. For example, a district-wide student study team in one district includes several community agency representatives and serves as a resource to case managers who face service barriers. These case managers report that the team is able to "cut red tape" and quickly provide families with access to needed services.

- Reduces fragmentation and redundancy of service delivery to children and families receiving services from several service systems simultaneously. For example, several case managers report that their increased contact with parents, combined with follow-up meetings and service plan revisions, have helped to make efficient "midstream" adjustments when needed services have not been received or some services are no longer needed.

- Enhances early interventions and prevention activities with siblings of referred children who as yet are not identified as at risk of school failure. For example, in one school, case managers worked with parents, counselors, and teachers of targeted students and assessed family needs and resources. Service plans were developed which assigned one case manager to work with all siblings in a family, regardless of the school attended.

- Coordinates, integrates, and properly sequences a variety of services to common clients from different agencies which serves to ensure a maximum collective impact on

children and minimum interagency rivalry, frustration, obstruction, or worse. For example, case managers have developed close working relationships with service providers, enabling them to act as a respected advocate and coordinator for families receiving multiple services.

- Energizes human service providers in that it provides nontraditional opportunities for educators, health service workers, and social workers to work in fresh settings with different professionals in an atmosphere of shared and ongoing professional development. It can provide routine opportunities for educators, social workers, and health service professionals to learn about another's technique regarding what's working and not working with their common client populations. For example, a county health nurse and mental health professional meet regularly with one district's case management team. These professionals inform the school staff about available services and treatment options.

Getting Started

Schools, community-based agencies, and institutions of higher education all have a variety of unique and exciting opportunities to forge new types of partnerships with the communities they serve in common. Of course this means we will all have to change how we do business. Some first steps you may want to consider are:

- Invite your professional neighbors to your school campus for an informal "brown bag" lunch meeting. Get acquainted and look into networking potentials. Elementary school faculties can now look beyond their school campus boundaries and identify who else is out there with the professional expertise and shared responsibilities to serve the children and their families residing in their attendance areas. Sometimes all it takes is asking.

- Take some risks in not taking "no" upon first contact with some of the gatekeepers of the bureaucracies with whom you are attempting to link. You may want to initiate contact(s) with state and local officials responsible for administration of categorical programs such as Title 1 and Medicaid to explore existing levels of flexibility that now allow schools and community-based agencies to decategorize their respective funding streams and pool resources in support of school-based integrated service delivery. Several policymakers at federal and state levels of government have created waiver processes designed to "quick start" creative budgeting across service systems. In our experience, these waiver mechanisms frequently are not fully understood or appreciated at the local level.

- Invite your local institutions of higher education to join your new partnership. Professional schools of universities that train your school faculties and the nurses, social workers, and other human service providers you are partnering with are increasingly adjusting preservice degree requirements and in-service offerings to include a focus on interprofessional collaboration.

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Al Smith received his Ph.D. in Educational Policy and Leadership Studies from the University of Washington in 1983. He is a faculty member in the College of Education at the University of Washington. He is the founder and director of the college's Center for the Study and Teaching of At-Risk Students (C-STARS). For the past eight years, this Center has been demonstrating and evaluating school-based integrated service approaches to dropout prevention. Dr. Smith is a charter member of the National Dropout Prevention Network, a member of the Editorial Board of the *Journal of At-Risk Issues*, and serves on the Executive Committee of the National Dropout Prevention Coalition. In addition to dropout prevention, much of the current C-STARS focus is directed at demonstrating applications of the C-STARS school-based case management model to school counselor roles and school-to-work transition programs. Dr. Smith is a former elementary teacher and principal and also has a faculty appointment with the university's School of Social Work.

The National Dropout Prevention Center (NDPC) is a partnership of concerned leaders—representing business, educational and policy interests, and Clemson University—created to significantly reduce America's dropout rate. NDPC is committed to meeting the needs of youth in at-risk situations by helping to shape school environments which ensure that all youth receive the quality education to which they are entitled. NDPC provides technical assistance to develop, demonstrate, and evaluate dropout prevention efforts; conducts action research; and collects, analyzes, and disseminates information about efforts to improve the schooling process.